§ 9792.6. Utilization Review Standards--Definitions

As used in this Article:

~~(a) "ACOEM Practice Guidelines" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.~~

(a) “Approval” means a decision that the requested treatment or service is authorized.

(b) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on ~~the~~ a completed ~~Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician's Progress Report,” DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2~~ “Request for Authorization for Medical Treatment,” DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9, and may be provided by utilizing the indicated response section of the “Request for Authorization for Medical Treatment,” DWC Form RFA.

(c) “Business day” means, for the purposes of article 5.5.1, the same meaning as ‘working’ day under Labor Code section 4610 and shall mean Monday through Friday between the hours of 9 AM and 5:30 PM Pacific Standard Time, and shall exclude Saturday, Sunday and each state or federal holiday.

(d)~~(c)~~ "Claims Administrator" is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.

(e)~~(d)~~ "Concurrent review" means utilization review conducted during an inpatient stay.

(f)~~(e)~~ "Course of treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.

(g) “Delay” means a decision by a physician reviewer that no determination based on medical necessity may be made within the 14-day time limit for the reasons listed in 9792.9(f).

(h) “Denial” means a decision by a physician reviewer that the requested treatment or service is not medically necessary.

(i)~~(f)~~ "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(j)~~(g)~~ "Expedited review" means utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

(k)~~(h)~~ "Expert reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

(l)~~(i)~~ "Health care provider" means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

(m)(j) "Immediately" means within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions specified, in subdivision~~s (b)(1), (b)(2) or~~ (c) and (f)~~(g)~~(1) of section 9792.9.

(n)~~(k)~~ "Material modification" ~~is when the claims administrator changes~~ means a change of Medical Director or utilization review vendor or ~~makes~~ a change to the utilization review standards adopted in a plan as specified in section 9792.7, including, but not limited to, a change of policies or practices described in an approved utilization plan.

(o)~~(l)~~ "Medical Director" is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process and ensuring that all reviewers are licensed as required in article 5.5.1.

(p)~~(m)~~ "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(q) “Medical Treatment Utilization Schedule” means the evidence-based, peer-reviewed, nationally recognized standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in California Code of Regulations, title 8, sections 9792.20 et seq.

(r) “Modification” means a decision by a physician reviewer that part of the requested treatment or service is medically necessary.

(s) "Prior authorization" means an arrangement written into the utilization review plan that describes the specific conditions or circumstances under which a treating physician will be assured of appropriate reimbursement for specific treatment without the need to submit a DWC Form RFA or other document before, during or after the specific treatment other than the bill for such treatment. The plan description of the prior authorization process must clearly describe what treatment qualifies, what conditions the treating physician must satisfy and how the treating physician will be informed about treatment that falls outside of the prior authorization arrangement under the plan.

(t)~~(n)~~ "Prospective review" means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services. “Pre-authorization” and “prospective review” have the same meaning in the California workers’ compensation utilization review process.

(u)~~(o)~~ "Request for authorization" means a written ~~confirmation of an oral~~ request for a specific course of proposed medical treatment ~~pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment~~. ~~An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written~~ A request for authorization must be set forth on a completed “Request for Authorization for Medical Treatment (DWC Form RFA),” as contained in California Code of Regulations, title 8, section 9785.5. “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that information specific to the request has been provided by the requesting physician for all mandatory fields indicated on the DWC Form RFA. The form must be signed by the physician and may be mailed, faxed or e-mailed. ~~the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.~~

(v)~~(p)~~ "Retrospective review" means utilization review conducted after medical services have been provided that do not fall within the utilization review plan’s ‘prior authorization’ arrangement and for which approval has not already been given.

(w)~~(q)~~ "Reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner who holds an unrestricted license~~d by~~ from any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice as defined by the California licensing board.

(x) “Utilization review organization” means any person or entity with which the employer, or an insurer, or third party administrator, contracts to fulfill part or all of the employer's utilization

review responsibilities under Labor Code section 4610 and California Code of Regulations, title 8, sections 9792.6 through 9792.15.

(y)~~(r)~~ "Utilization review plan" means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

(z)~~(s)~~ "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed. The utilization review process begins when the DWC Form RFA is first received, whether by the employer's claims administrator or utilization review organization, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

(aa)~~(t)~~ "Written" includes a communication transmitted by facsimile, electronic mail, or ~~as well as communications~~ in paper form.

§ 9792.7. Utilization Review Standards--Applicability

(a) Effective January 1, 2004, every claims administrator shall establish and maintain a utilization review process for treatment rendered on or after January 1, 2004, regardless of date of injury, in compliance with Labor Code section 4610. Each utilization review process shall be set forth in a utilization review plan. Beginning on July 1, 2011, each claims administrator shall annually submit a statement of no changes if there have been no changes to its approved utilization plan. The plan ~~which~~ shall contain:

(1) The name, address, phone number, and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(2) A description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(3) A description of the specific medical criteria utilized routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process. Samples of letters used to convey a decision to approve, modify, delay or deny a request for authorization shall be a part of the plan and shall be submitted for review. A description of the personnel and other sources used in the development and review of the criteria, and methods for updating the criteria. ~~Prior to and until the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the~~ The written policies and procedures governing the utilization review process shall be described and shall be consistent

with the recommended standards set forth in the Medical Treatment Utilization Schedule as contained in California Code of Regulations, title 8, section 9792.20 et seq. ~~the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition. The Administrative Director incorporates by reference the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), Second Edition (2004), published by OEM Press. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com). After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in that schedule.~~

(4) A description of the qualifications and functions of the other medical and non-medical personnel involved in decision-making and implementation of the utilization review plan.

(5) A description of the claims administrator's practice, if applicable, of any prior authorization process as defined in California Code of Regulations, title 8, section 9792.6(r)~~, including but not limited to, where authorization is provided without the submission of the request for authorization~~.

(b)(1) The medical director shall ensure that the process by which the claims administrator reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610 and these implementing regulations.

(2) A reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of practice, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

(3) A non-physician reviewer may ~~be used to~~ initially apply specified medical criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable medical criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the medical criteria provided under the plan. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in section 9792.9 subdivision~~s~~ ~~(b)(1), (b)(2) or~~ (c). ~~Any time beyond the time specified in these paragraphs is subject to the provisions of subdivision (g)(1)(A) through (g)(1)(C) of section 9792.9.~~ A non-physician may not make or sign a decision to delay, modify or deny recommended treatment.

(c)(1) The ~~complete~~ initial utilization review plan shall state the effective date of the plan. Any revisions or modifications to the plan shall state the effective date of the revision or

modifications. The plan , ~~consisting of the policies and procedures, and a description of the utilization review process,~~ shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director.

(2) In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director. ~~A~~

(3) A modified utilization review plan or utilization plan which has any material change shall be filed with the Administrative Director within 15 ~~30~~ calendar days of the effective date of the modification or change.~~after the claims administrator makes a material modification to the plan.~~

(d) A claims administrator or external utilization review organization may use the utilization review plan template that is posted on the DWC website at: http://www.dir.ca.gov/dwc/UR_Main.htm

(e) A list of approved utilization review plans will be posted on the DWC website at: http://www.dir.ca.gov/dwc/UR_Main.htm. Utilization review plans were approved prior to the effective date of these regulations that are included on the approved list do not need to resubmit the utilization review plan for approval until they are revised or modified.

(f) The Administrative Director will notify the claims administrator or external utilization review organization within sixty (60) days of receipt of a complete plan or plan revision, whether the utilization review plan or plan revision is approved or requires additional modification.

(1) If a notice of approval is not issued by the Medical Unit within 60 days of receipt of a plan or plan revision, the claims administrator or utilization review organization shall not be subject to penalties for plan deficiencies until a notice of plan disapproval has been issued and the claims administrator has failed to file a plan revision in compliance with subdivision 9792.7(f)(2) below.

(2) A response to a notice of plan disapproval shall be provided to the Medical Unit within 30 days of receipt of the disapproval.

(3) A notice of plan approval will issue once the Administrative Director has determined the plan or plan revision is compliant, where the plan was previously disapproved.

(g) (1) A claims administrator or external utilization review organization that fails to respond to a notice of plan disapproval, by filing a plan revision in compliance with the Labor Code section 4610 and sections 9792.6 through 9792.10 within 30 days of receipt of the disapproval notice, shall be subject to penalties for non-compliance as set forth in section 9792.12.

(2) When a plan disapproval notice is issued, the Medical Unit shall issue a final report and notice of utilization review penalty assessment. If the claims administrator or utilization review organization corrects the deficiencies as described in the notice of plan disapproval and pays the penalties within thirty (30) calendar days, the notice of utilization review penalty assessment shall be deemed a Stipulated Order. If the claims administrator or utilization review organization disputes any or all of the penalties, it shall follow the procedure set forth in section 9792.15.

(h) An employer that fails to file utilization review plan, a letter in lieu of utilization review plan, annual statement of no changes to an approved plan, or plan revisions when applicable shall be subject to penalties for non-compliance as set forth in section 9792.12. The Medical Unit shall issue a final report and notice of utilization review penalty assessment. If the claims administrator or utilization review organization corrects the deficiencies as described in the notice of plan disapproval and pays the penalties within thirty (30) calendar days, the notice of utilization review penalty assessment shall be deemed a Stipulated Order. If the claims administrator or utilization review organization disputes any or all of the penalties, it shall follow the procedure set forth in section 9792.15.

(i)~~(d)~~ The claims administrator or external utilization review organization shall make available at no charge a complete copy of the utilization review plan used to review specific treatment, upon request by an injured employee or his or her attorney, or by the requesting physician. Upon request by the public, the claims administrator shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process.

(1) The claims administrator may make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process, through electronic means.

(2) If a member of the public requests a hard copy of the utilization review plan, the claims administrator may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $ 0.25 per page plus actual postage costs.

§ 9792.8. Utilization Review Standards--Medically-Based Criteria

(a)(1) The medical criteria used in a utilization review plan shall be consistent with the Medical Treatment Utilization Schedule (MTUS) as contained in California Code of Regulations, title 8, section 9792.20 et seq. ~~schedule for medical treatment utilization adopted pursuant to Labor Code section 5307.27. Prior to adoption of the schedule, the criteria or guidelines used in the utilization review process shall be consistent with the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, Second Edition.~~ The MTUS ~~guidelines set forth in the ACOEM Practice Guidelines~~ shall be presumptively correct on the issue of extent and scope of medical treatment ~~until the effective date of the utilization schedule adopted pursuant to Labor Code section 5307.27~~. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the MTUS ~~guidelines~~ is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

(2) For all conditions or injuries not addressed by the MTUS ~~ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Labor Code section 5307.27~~, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically

based. Treatment may not be denied on the sole basis that the treatment is not addressed by the MTUS ~~ACOEM Practice Guidelines until adoption of the medical treatment utilization schedule pursuant to Labor Code section 5307.27. After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, treatment may not be denied on the sole basis that the treatment is not addressed by that schedule~~.

(3) The written statement of a denial, modification, or delay in the utilization review decision letter shall clearly cite the specific, relevant medical criteria or guidelines text used in making the decision by quoting or paraphrasing the relevant information and by explaining how such criteria or guideline applies to the injured employee's clinical condition and the treatment at issue. The decision shall not cite or quote or paraphrase criteria or guidelines which are not relevant to the clinical situation and the specific treatment request under consideration. The statement ~~relevant portion of the criteria or guidelines used~~ shall be disclosed in written form to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney~~, if used as the basis of a decision to modify, delay, or deny services in a specific case under review~~. The claims administrator may not charge an injured worker, the injured worker's attorney or the requesting physician for a copy of the relevant portion of the criteria or guidelines used to modify, delay or deny the treatment request.

(4) Nothing in this section precludes authorization of medical treatment ~~not included in the specific criteria under section 9792.8(a)(3)~~.

§ 9792.9. Utilization Review Standards--Timeframe, Procedures and Notice Content

(a) The request for authorization for a course of treatment as defined in section 9792.6~~(e)~~(f) must be in written form set forth on the "Request for Authorization for Medical Treatment (DWC Form RFA)," as contained in California Code of Regulations, title 8, section 9785.5.

(1) For purposes of this section, the ~~written request for authorization~~ DWC Form RFA shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the ~~request~~ form was received if the receiving facsimile or electronical mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the ~~request~~ form was transmitted shall be deemed to be the date the form was received by the claims administrator or the calims administrator's utilization review organization. A ~~request for authorization~~ DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. ~~As defined in Labor Code section 4600.4 and in section 9 of the Civil Code~~. The copy of the ~~request for authorization~~ DWC Form RFA or the cover sheet accompanying the form ~~received~~ transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the ~~request~~ form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall ~~contain~~ display either the facsimile telephone number to which the ~~request~~ form was transmitted. The requesting physician must indicate if there is the need for an expedited review on ~~upon submission of~~ the ~~request~~ DWC form RFA.

(2) (A) Where the ~~request for authorization~~ DWC Form RFA is ~~made~~ sent by mail~~, and a proof of service by mail exists,~~ the ~~request~~ form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.
(B) Where the ~~request for authorization~~ DWC Form RFA is delivered via certified mail, with return receipt mail, the ~~request~~ form, absent documentation of receipt, shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt.
(C) In the absence of ~~a proof of service by mail~~ documentation of receipt, evidence of mailing, or a dated return receipt, the ~~request~~ DWC Form RFA shall be deemed to have been received by the claims administrator ~~on the date stamped as received on the document~~ five days after the latest date the sender wrote on the document.

(b) ~~The utilization review process shall meet the following timeframe requirements:~~
~~(h)~~ Every claims administrator shall maintain telephone access have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time~~,~~ on ~~normal~~ business days~~,~~ for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. For purposes of this section ~~"normal business day" means a business day as defined in Labor Code section 4600.4 and Civil Code section 9. In addition, for purposes of this section~~ the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

(c) Timeframes.

(1) The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

(2) If the DWC Form RFA is not completed as defined in section 9792.6(u), a non-physician reviewer or reviewer may either treat the form as complete and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete" no later than five (5) business days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

(3)~~(b)(1)~~ Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) ~~working~~ business days from the date of receipt of the ~~written request for authorization~~ completed DWC Form RFA, but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA.

(A)~~(e)~~ Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must indicate the need for an expedited review upon submission of the request. ~~Decisions related to expedited review refer to the following situations:~~

~~(1) When the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or~~

~~(2) The normal timeframe for the decision-making process, as described in subdivision (b), would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.~~

(B)~~(b)(2)~~ If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) ~~working~~ business days from the date of receipt of the ~~written request for authorization~~ DWC Form RFA to make the proper determination. ~~In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider.~~

(C) ~~(b)(2)(A)~~ If the reasonable information requested by ~~the claims administrator~~ a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the DWC Form RFA is not received within 14 days ~~of the date of the original written request by the requesting physician~~ from receipt of the DWC Form RFA, ~~a~~ the reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested, or the reviewer may issue a decision to delay as provided in subdivision (f)(1)(A).

(4) In the case of a request for authorization for spinal surgery as defined in California Code of Regulations, title 8, section 9788.01(l), the decision to approve the requested surgery or to request additional reasonable medical information necessary to make the decision shall be made in a timely fashion that is appropriate for the injured worker's condition, not to exceed five (5) business days from receipt of a completed DWC Form RFA. A decision to modify or deny the requested spinal surgery must be made within five (5) business days from receipt of a complete DWC Form RFA. When additional information has been previously requested, a decision to modify or deny the requested spinal surgery must be made within the ten (10) calendar day period for objections provided under Labor Code section 4062(b), notwithstanding any timeframes that exceed ten (10) calendar days in Labor Code section 4610 or elsewhere in article 5.5.1 of these regulations. An objection by the claims administrator made pursuant to Labor Code section 4062(b) to the requested spinal surgery must be communicated separately no later than ten (10) calendar days from receipt of the treating physician report recommending spinal surgery, in addition to the decision made through utilization review and must be in compliance with the requirements of California Code of Regulations, title 8, sections 9788.1 *et seq* and Labor Code section 4062(b)

(5) Retrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the medical information that is reasonably necessary to make this determination.

~~(c) When review is retrospective, decisions shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and~~

~~his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.~~

(d) Decisions to approve a request for authorization.

(1)~~(i) A written decision approving~~ All decisions to approve a request for ~~treatment~~ authorization ~~under this section~~ set forth in a DWC Form RFA shall specify the specific medical treatment service requested, the specific medical treatment service approved, and the date of the decision.
(2) ~~(b)(3)~~ For prospective, concurrent, or expedited review, approvals ~~Decisions to approve a physician's request for authorization prior to, or concurrent with, the provision of medical services to the injured worker~~ shall be communicated to the requesting physician within 24 hours of the decision~~. Any decision to approve a request~~, and shall be communicated to the requesting physician initially by telephone ~~or~~, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.
(3)(A) For retrospective review, a written decision to approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.
~~(c) When review is retrospective, decisions shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.~~
(B) Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe set forth above, shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of benefits, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

(e) Decisions to modify, delay, or deny a request for authorization.

~~(b)(4) Decisions to modify, delay or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the~~

~~decision for concurrent review and within two business days of the decision for prospective review. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.~~

~~(b)(5) For purposes of this section "normal business day" means a business day as defined in Labor Code section 4600.4 and Civil Code section 9.~~

(1)~~(f)~~ The review and decision to deny, delay, or modify a request for medical treatment must be conducted by a reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.

(2)~~(d)~~ Failure to obtain ~~prior~~ authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

(3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

(4) For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

(5) ~~(j)~~ A written decision modifying, delaying or denying treatment authorization ~~under this section~~ shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall only contain the following information specific to the request:

(A) The date on which the DWC Form RFA was first received.

~~(1) The date on which the decision is made.~~

(B) ~~(2)~~ A description of the specific course of proposed medical treatment for which authorization was requested.

(C) ~~(3)~~ A specific description of the medical treatment service approved, if any.

(D) ~~(4)~~ A clear ~~and~~, concise, and appropriate explanation of the reasons for the ~~claims administrator's~~ reviewing physician's decision, including ~~(6) T~~the clinical reasons regarding medical necessity and ~~(5) A~~ a description of the medical criteria or guidelines used to reach the decision pursuant to section 9792.8, subdivision (a)(3).

(E) A description of dispute resolution procedures:
(1) Except in the case of a dispute regarding a request for spinal surgery, a ~~(7)A~~ clear statement advising the injured employee that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062, and that an objection to the utilization review decision must be communicated by the injured worker or the injured worker's attorney on behalf of the injured worker to the claims administrator in writing within 20 calendar days of receipt of the decision. It shall further state that the 20-day time limit may be extended for good cause or by mutual agreement of the parties. The letter shall further state that the injured worker may file an Application for Adjudication of Claim and a Declaration of Readiness to Proceed (expedited trial) and ~~R~~request ~~for~~ an ~~E~~expedited ~~H~~hearing~~, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with sections 10136(b)(1), 10400, and 10408~~ and decision on his or her entitlement to medical treatment if the request for medical treatment is not authorized within the time limitations set forth in section 9792.9, or when there exists a bona fide dispute as to entitlement to medical treatment.
(2) In the case of a dispute regarding a request for spinal surgery, a clear statement advising the injured employee that even when the recommended surgery is denied or modified in the utilization review process, the claims administrator may initiate the spinal surgery second opinion process under Labor Code section 4062(b) by filing a DWC Form 233 (Objection to Treating Physician's Recommendation for Spinal Surgery) within 10 calendar days of receipt of the DWC Form RFA.

(F) ~~(8)~~ Include the following mandatory language advising the injured employee:

~~Either~~

~~"If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401.~~

~~or~~

"If you want further information, you may contact the local state Information and Assistance office closest to you. Please see attached listing (attach a listing of I&A offices and telephone numbers) or you may receive recorded information by calling 1-800-736-7401."

~~and~~

"You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits."

~~In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing~~

~~of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.~~

(G)~~(9)~~ Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is ~~on~~ a voluntary ~~basis~~ process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4062, but may be pursued on an optional basis, including the following mandatory statement:

"If you, as the injured worker, disagree with the utilization review decision and wish to dispute it, you may initiate formal dispute resolution procedures under Labor Code section 4062 by sending an objection to the claims administrator. To begin the Labor Code section 4062 procedures, you must send written notice of your objection to the claims administrator within 20 calendar days of receipt of the utilization review decision ~~in accordance with Labor Code section 4062.~~ Your treating physician may concurrently advise the claims administrator or utilization reviewer in writing that they wish to participate in the claims administrator's optional, voluntary internal utilization review appeals process." ~~You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process."~~

(6) ~~(k)~~ The written decision modifying, delaying or denying treatment authorization ~~provided~~ that is sent to the requesting physician shall also contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during ~~normal~~ business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

(f)~~(g)~~(1) The timeframe for decisions specified in subdivisions ~~(b)(1), (b)(2) or~~ (c) may only be extended with a written notice of delay by the claims administrator or reviewer under one or more of the following circumstances:

(A) The ~~claims administrator~~ reviewer is not in receipt of all of the necessary medical information reasonably requested.

(B) The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

(C) The ~~claims administrator~~ reviewer needs a specialized consultation and review of medical information by an expert reviewer who is not a reviewer ordinarily used by the claims administrator or utilization review organization, and who has expertise not possessed by a reviewer ordinarily used by the organization.

(2)~~(a)~~ If subdivisions (f)(1)(A), (B) or (C) above apply, the claims administrator or reviewer shall immediately notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the ~~claims administrator~~ reviewer cannot make a decision within the required timeframe, and specify the information requested but not received, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The claims administrator or reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered. This notice shall include a statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim and ~~Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136(b)(1), 10400, and 10408. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision to extend the timeframe and the anticipated date on which the decision will be rendered in accordance with this subdivision. The written notification shall not include the rationale, criteria or guidelines used for the decision.~~ a Declaration of Readiness to Proceed (expedited trial) and request an expedited hearing and decision on his or her entitlement to medical treatment.

~~(b) In the event notice of the decision is provided to a non-physician provider of goods and services, the The written notification shall not include the rationale, criteria or guidelines used for the decision.~~

~~(g)~~(3)(A) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C) ~~above, and (b)(2)(A),~~ the claims administrator or reviewer, for prospective or concurrent review, shall make the decision to approve, ~~and the reviewer shall make a decision to~~ modify, delay, or deny the request for authorization within five (5) ~~working~~ business days of receipt of the information ~~for prospective or concurrent review~~. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision The written decision shall ~~be communicated pursuant to subdivisions (b)(3) or (b)(4)~~ include the date the information was received and the decision shall be communicated in the manner set out in section 9792.9 (d) or (e), whichever is applicable.

(4) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, delay, or deny the request for authorization within 72 hours of receipt of the information, and for all other prospective or concurrent decisions, within 24 hours of the decision for concurrent review, or two business days for prospective review. The written notice of decision shall include the date the requested information was received and be communicated pursuant to subdivisions (d)(2) or (e)(3), whichever is applicable.

(5)~~(g)(4)~~ Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C)~~ above~~, the claims administrator or reviewer, for retrospective review, shall make the decision to approve, ~~and the reviewer shall make a decision to~~ modify, delay, or deny the request for authorization within thirty (30) calendar days of receipt of the information ~~for retrospective~~

~~review~~ requested. ~~Except for a decision communicated under subdivision (d)(3)(B), t~~The decision shall include the date it was made and be communicated pursuant to subdivisions (d)(3) or (e)(4), whichever is applicable.

(g) Whenever a claims administrator or its utilization review organization issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile or mail.

~~(l) Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods or services identified in the request for authorization either by facsimile or mail.~~

§ 9792.10. Utilization Review Standards--Dispute Resolution

(a)(1) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code section 4062.

(2) Except in the case of disputed spinal surgery, an ~~An~~ objection to a decision disapproving in whole or in part a request for authorization of medical treatment, must be communicated to the claims administrator by the injured worker or the injured worker's attorney in writing within 20 days of receipt of the utilization review decision. The 20-day time limit may be extended for good cause or by mutual agreement of the parties. In the case of recommended spinal surgery, unless the surgery is approved, the claims administrator must perform utilization review and, if desired, make an objection within ten (10) calendar days of receipt of the DWC Form RFA for spinal surgery by filing the DWC Form 233 in compliance with California Code of Regulations, title 8, sections 9788.01 *et seq*.

(3) Nothing in this paragraph precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the injured worker and if the injured worker is represented by counsel, the injured worker's attorney have been notified of the 20-day time limit to file an objection to the utilization review decision in accordance with Labor Code section 4062.

(4) Additionally, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim~~,~~ and a Declaration of Readiness to Proceed (expedited trial) ~~Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136(b)(1), 10400, and 10408~~, and request an expedited hearing and decision on his or her entitlement to medical treatment if the request for medical treatment is not authorized within the time limitations set forth in section 9792.9, or when there exists a bona fide dispute as to entitlement to medical treatment.

(b) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

(2) Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury.

§ 9792.11. Utilization Review Plan Submission and Review; Utilization Review Investigation Procedures~~: Labor Code §4610 Utilization Review Violations~~

(a) Utilization Plan Reviews: The DWC Medical Unit shall have exclusive oversight for utilization review plans, annual statements of no changes, and updated utilization review plans for compliance with Labor Code section 4610 and California Code of Regulations, title 8, section 9792.7.

(b)~~(a)~~ To carry out the responsibilities mandated by Labor Code Section 4610(i), the Administrative Director, or his or her designee, shall investigate the utilization review process of any employer, insurer or other entity subject to the provisions of section 4610. The investigation shall include, but not be limited to, review of the practices, files, documents and other records, whether electronic or paper, of the claims administrator, and any other person responsible for utilization review processes for an employer. ~~As used in sections 9792.11 through 9792.15, the phrase 'utilization review organization' includes any person or entity with which the employer, or an insurer, or third party administrator, contracts to fulfill part or all of the employer's utilization review responsibilities under Labor Code section 4610 and Title 8 of the California Code of Regulations, sections 9792.6 through 9792.15.~~

~~(b) Notwithstanding Labor Code section 129(a) through (d) and section 129.5 subdivisions (a) through (d), the Administrative Director, or his or her designee, may conduct a utilization review investigation pursuant to Labor Code section 4610, which may include, but is not limited to, an audit of files and other records.~~

(c) The Administrative Director, or his or her designee, may conduct a utilization review investigation at any location where Labor Code Section 4610 utilization review processes occur, as follows:

(1)~~ For utilization review organizations:~~ Routine Investigations

(A) A Routine Investigation shall be initiated at each known utilization review organization at least once every ~~three (3)~~ five (5) years. A Routine Investigation shall be initiated at each claims adjusting location at least once every five (5) years concurrent with the profile audit review done pursuant to Labor Code sections 129 and 129.5. The investigation shall include a review of a random sample of requests for authorization, as defined by section 9792.6~~(o)~~(u), received by the

~~utilization review organization~~ investigation subject during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation. The investigation may also include a review of any credible complaints received by the Administrative Director over the past three years ~~since the time of the previous investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15~~.

(B) Target Investigations:

1. A Return Target Investigation of the same investigation subject shall be conducted within 18 months of the date of the previous investigation if the performance rating was less than eighty-five percent.

2. A Special Target Investigation may be conducted at any time based on credible information indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.

3. The Return Target Investigation and the Special Target Investigation may include: ~~(i) a review of the requests for authorization previously investigated which contained violations;~~ (ii) a review of the file or files pertaining to ~~the~~ a complaint ~~or possible violation~~; (iii) a random sample of requests for authorization received by the utilization review organization during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation; (iii~~v~~) a sample of a specific type of request for authorization; and (iv) any credible complaints received by the Administrative Director over the past 3 years prior to the Notice of Complaint Investigation. ~~since the time of any prior investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.~~

~~(2) For a claims administrator:~~

~~(A) A Routine Investigation shall be initiated at each claims adjusting location at least once every five (5) years concurrent with the profile audit review done pursuant to Labor Code sections 129 and 129.5. The investigation shall include a review of a random sample of requests for authorization, as defined by section 9792.6(o), received by the claims administrator during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the previous investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.~~

~~(B) Target Investigations:~~

~~1. A Return Target Investigation of the same investigation subject shall be conducted within 18~~

~~months of the date of any previous investigation if the performance rating was less than eighty-five percent.~~

~~2. A Special Target Investigation may be conducted at any time based on credible information indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.~~

~~3. The Return Target Investigation and the Special Target Investigation may include: (i) a review of the requests for authorization previously investigated which contained violations; (ii) a review of the file or files pertaining to the complaint or possible violation; (iii) a random sample of requests for authorization received by the claims administrator during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation; (iv) a sample of a specific type of request for authorization; and (v) any credible complaints received by the Administrative Director since the time of any prior investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.~~

4. Upon initiating a Special Target Investigation, the Administrative Director, or his or her designee, shall provide to the claims administrator or the utilization review organization a written description of the factual information or of the complaint containing factual information or a copy of the complaint that triggered the utilization review investigation, unless the Administrative Director or his or her designee determines that providing the information would make the investigation less useful. The claims administrator or utilization review organization shall have ten (10) business days upon receipt of the written description or copy of the complaint to provide a written response to the Administrative Director or his or her designee. After reviewing the written response, the Administrative Director, or his or her designee, shall either close the investigation without the assessment of administrative penalties or conduct further investigation to determine whether a violation exists and whether to impose penalty assessments.

5. ~~(j)~~ Unless the Administrative Director in his or her discretion determines that advance notice will render a Special Target or Return Target Investigation less useful, the claims administrator or utilization review organization shall be notified of its selection for an ~~i~~investigation.

(d) Claims administrators and utilization review organizations shall be sent a Notice of Utilization Review Investigation. The Notice of Utilization Review Investigation shall require the investigation subject to provide the following:

(1) ~~A description of the system used to identify each request for authorization (if applicable). To the extent the system identifies any of the following information in an electronic format, t~~The claims administrator or utilization review organization shall provide in an electronic format a list of each ~~and every~~ request for authorization (completed DWC Form RFA) received at the investigation site during a three month calendar period specified by the Administrative Director, or his or her designee~~,~~. ~~and t~~The following data elements shall be included for each request listed: i) a unique identifying number for each ~~request for authorization~~ completed DWC Form RFA, if one has been assigned; ii) the name of the injured worker; iii) the claim

number used by the claims adjuster; iv) the initial date of receipt of the request for authorization; v) the type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, ~~appeal~~); vi) the disposition (approve, deny, delay, modify~~, withdrawal~~); and, vii) the date of the decision ~~if applicable, the type of person who withdrew the request (requesting physician, claims adjuster, injured employee or his or her attorney, or other person)~~. In the event the claims administrator or utilization review organization is not able to provide the list in an electronic format, the list shall be provided in such a form that the listed requests for authorization ~~are sorted in the following order: by type of utilization review, type of disposition, and date of receipt of the initial request;~~ shall include the same data as required for the electronic list.

~~(2) A description of all media used to transmit, share, record or store information received and transmitted in reference to each request, whether printed copy, electronic, fax, diskette, computer drive or other media;~~

~~(3) A legend of any and all numbers, letters and other symbols used to identify the disposition (e.g. approve, deny, modify, delay or withdraw), type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal), and other abbreviations used to document individual requests for authorization and a data dictionary for all data elements provided;~~

~~(4) A description of the methods by which the medical director for utilization review ensures that the process by which requests for authorization are reviewed and approved, modified, delayed, or denied is in compliance with Labor Code section 4610 and sections 9792.6 through 9792.10, as required by sections 9792.6(l) and 9792.7(b) of Title 8 of the California Code of Regulations; and~~

(2)~~(5)~~ The following additional information, may be requested by the Administrative Director or his or her designee, as applicable to the type of entity investigated: i) whether utilization review services are provided externally; ii) the name(s) of the utilization review organization(s); iii) the name and address of the employer; and iv) the name and address of the insurer.

(e)~~(k)~~ The utilization review organization or claims administrator shall provide the requested information listed in subdivision (d)~~(j)~~ within fourteen (14) calendar days of receipt of the Notice of Utilization Review Investigation. Based on the information provided, the Administrative Director, or his or her designee, ~~shall~~ will provide the claims administrator or utilization review organization with a Notice of Investigation Commencement, which ~~shall~~ will include a list of randomly selected requests for authorization from ~~a~~ the three month calendar period designated by the Administrative Director and any complaint files ~~(if applicable)~~ for investigation.

(f)~~(d)~~ The number of requests for authorization randomly selected for investigation shall be determined based on the following table:

Population of requests for

authorization received during a three month calendar period	Sample Size
5 or less	all
6-10	1 less than total
11-13	2 less than total
14-16	3 less than total
17-18	4 less than total
19-20	5 less than total
21-23	6 less than total
24	17
25-26	18
27-29	19
30-31	20
32-33	21
34-36	22
37-39	23
40-41	24
42-44	25
45-48	26
49-51	27
52-55	28
56-58	29
59-62	30
63-67	31
68-72	32
73-77	33
78-82	34
83-88	35
89-95	36
96-102	37
103-110	38
111-119	39
120-128	40
129-139	41
140-151	42
152-164	43
165-179	44

180-197	45
198-217	46
218-241	47
242-269	48
270-304	49
305-346	50
347-399	51
400-468	52
469-562	53
563-696	54
697-905	55
906-1,272	56
1,273-2,091	57
2,092-5,530	58
5,531 +	59

(g)~~(e)~~ Complaints concerning utilization review procedures may be submitted with any supporting documentation to the Division of Workers' Compensation using the ~~sample~~ complaint form that is posted on the Division's website at:

http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf

Complaints should be mailed to DWC Medical Unit-UR, P.O. Box 71010, Oakland, CA 94612, attention UR Complaints or emailed to DWCManagedCare@dir.ca.gov. Complaints received by the Division of Workers' Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.

~~(f) Administrative penalties may be assessed for any failure to comply with Labor Code section 4610, or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, except that the penalties listed in section 9792.12(a)(6) through (14) and (b) shall only be imposed if the request was subject to the Labor Code section 4610 utilization review process~~.

(h) When ~~In the event~~ an investigation of utilization review processes is done at the claims administrator's adjusting location, concurrent with a profile audit review done pursuant to Labor Code section 129 or 129.5, the administrative penalty amounts for each violation of Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, shall be governed by sections 9792.11 through 9792.15. Any such administrative penalty for utilization review process violations shall apply in lieu of the administrative penalty amount allowed under the audit regulations at section 10111.2(b)(8)[vi] of Title 8, California Code of Regulations. In addition, any report of findings from the investigation and any notice of utilization review penalty assessment and performance rating ~~Order to Show Cause re: Assessment of Administrative Penalties prepared by the Administrative Director, or his or her~~

~~designee~~, based on violations of Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, shall be prepared separately from any audit report or assessment of administrative penalties made pursuant to Labor Code section 129 and 129.5. ~~The Order to Show Cause re: Assessment of Administrative Penalties for violations of sections 9792.6 et seq of Title 8 of the California Code of Regulations shall be governed by sections 9792.11 through 9792.15.~~

(i)~~(h)~~ The Administrative Director, or his or her designee, may also utilize the provisions of Government Code sections 11180 through 11191 to determine whether any violations of the requirements in Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, have occurred.

~~(i) Sections 9792.11 through 9792.15 of Title 8 of the California Code of Regulations shall apply to any Labor Code section 4610 utilization review investigation conducted on or after the effective date of sections 9792.11 through 9792.15 and for conduct which occurred on or after the effective date of sections 9792.11 through 9792.15.~~

[former subdivisions (j)(1) – (5) and (k) have been move above and is now (d)]

(j) The Notice of Investigation Commencement shall be provided at least fourteen (14) calendar days prior to the commencement of the investigation.

(l) For utilization review organizations: Within fourteen (14) calendar days of receipt from the Administrative Director, or his or her designee, of the Notice of Investigation Commencement, the utilization review organization shall deliver to the Administrative Director, or his or her designee, a true and complete copy of all records, whether electronic or paper, for each request for authorization listed. Copies of the records shall be delivered with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals, in his or her possession. After reviewing the records, the Administrative Director, or his or her designee, shall determine if an onsite investigation is required. If an onsite investigation is required, fourteen (14) calendar days notice shall be provided to the utilization review organization.

(2)~~(m)~~ For claims administrators: ~~The Notice of Investigation Commencement shall be provided to the claims administrator at least fourteen (14) calendar days prior to the commencement of the onsite investigation.~~ The claims administrator shall produce for the Administrative Director, or his or her designee, on the first day of commencement of the onsite investigation, the true, correct and complete copies, whether electronic or paper, whether located onsite or offsite, of each request for authorization identified by the Administrative Director or his or her designee, together with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals.

(k)~~(n)~~ In the event the Administrative Director, or his or her designee, determines additional records or files are needed for review during the course of an onsite investigation, the claims

administrator or utilization review organization shall produce the requested records in the manner described by subdivision 9792.11(d)~~(k)~~, within one (1) working day when the records are located at the site of investigation, and within five (5) working days when the records are located at any other site. Any such request by the Administrative Director or his or her designee also may include records or files pertaining to any complaint alleging violations of Labor Code sections 4610 or sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations. The Administrative Director or his or her designee may extend the time for production of the requested records for good cause.

~~(o) If the date or deadline in sections 9792.9(b) and 9792.9(c) of Title 8 of the California Code of Regulations to perform any act related to utilization review practices falls on a weekend or holiday, for the purposes of assessing penalties, the act may be performed on the next normal business day, as defined by Labor Code section 4600.4 and Civil Code section 9. This subdivision shall not apply in cases involving concurrent or expedited review. The timelines in sections 9792.9(b) of Title 8 of the California Code of Regulations shall only be extended as provided under section 9792.9(g) of that title.~~

~~(p) If the claims administrator or utilization review organization does not record the date a document is received, it shall be deemed received by using the method set out in section 9792.9(a)(2), except that:~~

~~(1) where the request for authorization is made by mail through the U.S. postal service and no proof of service by mail exists, the request shall be deemed to have been received by the claims administrator, or utilization review organization on whichever date is earlier, either the receipt date stamped by the addressee or within five (5) calendar days of the date stated in the request for authorization or where the addressee can show a delay in mailing by the postmark date on the mailing envelope then: (A) within five (5) calendar days of the postmark date, if the place of mailing and place of address are both within California; (B) within ten (10) calendar days if the place of address is within the United States but outside of California; or (C) within twenty (20) calendar days if the place of address, is outside of the United States; and~~

~~(2) where the request for authorization is made by express mail, overnight mail or courier without any proof of service, the request shall be deemed received by the addressee on the date specified in any written confirmation of delivery.~~

~~(q) Upon initiating a Special Target Investigation, the Administrative Director, or his or her designee, shall provide to the claims administrator or the utilization review organization a written description of the factual information or of the complaint containing factual information or a copy of the complaint that triggered the utilization review investigation, unless the Administrative Director or his or her designee determines that providing the information would make the investigation less useful. The claims administrator or utilization review organization shall have ten (10) business days upon receipt of the written description or copy of the complaint to provide a written response to the Administrative Director or his or her designee. After reviewing the written response, the Administrative Director, or his or her designee, shall either close the investigation without the assessment of administrative penalties or conduct further investigation to determine whether a violation exists and whether to impose penalty assessments.~~

(l)~~(r)~~ Retention of records

(1) For utilization review organizations,~~:~~ ~~T~~ the files and other records for any DWC Form RFA, whether electronic or paper, that pertain to the utilization review process shall be retained for at least ~~three (3)~~ five (5) years following either: (1) the most recent utilization review decision for each injured employee, or (2) the date on which any appeal from the assessment of penalties for violations of Labor Code section 4610 or sections 9792.6 through 9792.12 is final, whichever date is later.

(2) Claims administrators shall retain their claim files as set forth in section 10102 of Title 8 of the California Code of Regulations.

(m)~~(s)~~ Upon receipt of a notice of Routine or Target Investigation or any other request from the Administrative Director, or his or her designee, to review all files and other records pertaining to the employer's utilization review process, whether electronic or paper, that are created or held outside of California, the claims administrator or utilization review organization shall either deliver all such requested files and other records to an address in California specified by the Administrative Director, or his or her designee, or reimburse the Administrative Director for the actual expenses of each investigator who travels outside of California to the place where the records are held, including the per diem expenses, travel expenses and compensated overtime of the investigators.

(n)~~(t)~~ A preliminary investigation report will be provided to the claims administrator or utilization review organization. The preliminary investigation report shall consist of the preliminary notice of utilization review penalty assessments, the performance rating, and may include one or more requests for additional documentation or compliance. A conference to discuss the preliminary investigation report shall be scheduled, if necessary, within twenty-one calendar days from the issuance of the preliminary findings. ~~Following the conference, the Administrative Director or his or her designee shall issue an Order to Show Cause Re: Assessment of Administrative Penalty (which shall include the final investigation report), as set forth in section 9792.15.~~

(o) The Administrative Director or his or her designee shall issue a final report of investigation findings which may include, but is not limited to, the following: a description of the investigation process; notice of utilization review penalty assessment(s); the performance rating for the investigation; and, one or more requests for additional documentation or compliance.

(1) The final investigation report shall be served personally or sent by registered or certified mail to the investigation subject.

(2) If, within 30 days of receipt of the final report, the investigation subject does not dispute findings and complies with any requirements for payment of penalties and submission of documentation, the utilization review penalty assessment shall be deemed a Stipulated Order.

(3) If, after 30 days, there are any uncontested penalty assessments that are not paid or additional requested documentation is not provided, penalties for the investigation may be assessed under California Code of Regulations, title 8, sections 9792.12(a)(17).

~~(u) The claims administrator or utilization review organization may stipulate to the allegations and final report set forth in the Order to Show Cause.~~

(p) If the claims administrator or utilization review organization disputes any or all of the penalties, it shall follow the procedure set forth in section 9792.15.

(q) The investigator's working papers and findings for individual records are confidential.

~~(v) Within forty-five (45) calendar days of the service of the Order to Show Cause Re: Assessment of Administrative Penalties, if no answer has been filed, or within 15 calendar days after any and all appeals have become final, the claims administrator or utilization review organization shall provide the following:~~

~~(1) A notice, which shall include a copy of the final investigation report, the measures actually implemented to abate such conditions, and the website address for the Division where the performance rating and summary of violations is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of the final investigation report.~~

~~(2) For utilization review organizations: the notice must be served on any employer or third party claims administrator that contracted with the utilization review organization and whose utilization review process was assessed with a penalty pursuant to section 9792.12, and any insurer whose utilization review process was assessed with a penalty pursuant to section 9792.12.~~

~~(3) For claims administrators: the notice must be served on any self-insured employer and any insurer whose utilization review process was assessed with a penalty pursuant to section 9792.12.~~

~~(4) The notice shall be served by certified mail.~~

~~(5) Documentation of compliance with this section shall be served on the Administrative Director within thirty calendar days from the date the notice was served.~~

§ 9792.12. Administrative Penalty Schedule for Labor Code §4610 Utilization Review Violations

(a) Mandatory Administrative Penalties. Notwithstanding Labor Code section 129.5(c)(1) through (c)(3), the penalty amount that shall be assessed for each failure to comply with the utilization review process required by Labor Code section 4610 and sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations, is:

(1) For failure to establish a Labor Code section 4610 utilization review plan: $ 50,000;

(2) For failure to have a Labor Code section 4610 utilization review plan that was in effect during the time the randomly selected or a specific request for authorization was received by the claims administrator or utilization review organization: $ 50,000

(32) For failure to include all of the requirements of section 9792.7(a) in the utilization review plan within 30 calendar days of notice of non-approval by the Administrative Director: $ 5,000;

(43) For failure to file the utilization review plan or a letter in lieu of a utilization review plan with the Administrative Director as required by section 9792.7(c)(2): $ 10,000;

(5) For failure to file the annual statement of no changes or an updated utilization review plan with the Administrative Director as required by section 9792.7(a): $ 5,000;

(64) For failure to file a modified utilization review plan with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan as required by section 9792.7(c): $ 5,000;

(75) For failure to employ or designate a physician as a medical director, as defined in section 9792.6(l)(o), of the utilization review process, as required by section 9792.7(b): $ 50,000;

(86) For issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product where the requested treatment, procedure or service is not within the reviewer's scope of practice (as set forth by the reviewer's licensing board): $ 25,000;

(97) For failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve, except as provided for in Labor Code section 4604.5(d) and section 9792.9(c)(3)(B)(b)(2) and (3): $ 25,000;

(8) For failure of a non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations), who approves an amended request to possess an amended written request for treatment authorization as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: $ 1,000;

(109) For failure to communicate the decision in response to a request for an expedited review, as defined in section 9792.6(j)(g), in a timely fashion, as required by section 9792.9: $ 15,000;

(1110) For failure to approve the request for authorization solely on the basis that the condition for which treatment was requested is not addressed by the medical treatment utilization schedule adopted pursuant to section 5307.27 of the Labor Code: $ 5,000;

(1211) For failure to discuss or document attempts to discuss reasonable options for a care plan

with the requesting physician as required by Labor Code section 4610(g)(3)(B), prior to denying authorization of or discontinuing medical care, in the case of concurrent review: $ 10,000;

(13~~12~~) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a non-expedited concurrent review: $ 2,000;

(14~~13~~) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a non-expedited prospective review: $ 1,000;

(15~~14~~) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a retrospective review: $ 500;

(16~~15~~) For failure to disclose or otherwise to make available, if requested, the Utilization Review criteria or guidelines to the public, as required by Labor Code section 4610, subdivision (f)(5) and section 9792.7(i)~~(d)~~ of Title 8 of the California Code of Regulations: $ 100.

~~(16) For failure to timely serve the Administrative Director with documentation of compliance pursuant to section 9792.11(v)(5): $ 500.~~

(17) For failure to timely comply with any compliance requirement listed in the Final Report, including payment of any assessed penalty, if no timely answer was filed or any compliance requirement listed in the Determination and Order after any and all appeals have become final: $ 500.

(18) For failure to respond to the notice of investigation as required by sections 9792.11(e) and or (j): $ 500.

(b) Additional Penalties ~~and Remediation~~.

(1). For any request for authorization in which there is identified a failure to make and/or provide a timely response to a request for authorization there will be a penalty of $100;

(2) For any request for authorization in which there is identified faulty content in the response to a request for authorization there will be a penalty of $100; and

(3) For any request for authorization in which there is identified a failure to properly distribute the response to a request for authorization there will be a penalty of $50.

(c) Performance Rating

(1) ~~After conducting a Routine or Return Target Investigation, the~~ The Administrative Director, or his or her designee, shall calculate the investigation subject's performance rating ~~based on its review of the randomly selected requests. The investigation subject's performance rating may also be calculated after conducting a Special Target Investigation. The performance rating will be calculated~~ as follows:

(A) The factor for failure to make and/or provide a timely response to a request for authorization shall be determined by dividing the number of randomly selected requests with violations involving failure to make or provide a timely response to a request for authorization by the total number of randomly selected requests.

(B) The factor for notice(s) with faulty content shall be determined by dividing the number of requests involving notice(s) with faulty content by the total number of randomly selected requests.

(C) The factor for failure to issue notice(s) to all appropriate parties shall be determined by the number of requests involving the failure to issue notice(s) to all appropriate parties by the total number of randomly selected requests.

(D) The investigation subject's investigation performance rating will be determined by adding the factors calculated pursuant to subsections (b)(1)(A) through (b)(1)(C), dividing the total by three, subtracting from one, and multiplying by one-hundred.

(E) If the investigation subject's performance rating meets or exceeds eighty-five percent, the Administrative Director, or his or her designee, shall assess no penalties for the violations listed in this subdivision. If the performance rating is less than eighty-five percent, the ~~violations shall be assessed as set forth below in (b)(2) through (b)(5):~~ investigation subject shall be assessed the penalty amount pursuant to subdivision (b) and the penalty amounts shall be adjusted based on the size of the population of requests for authorization received during the three-month period from which the sample was drawn.

Less than 65:	1.0
65-99	1.2
100-249	1.4
250-499	1.6
500-749	1.8
750-999	2.0
1,000-1,499	2.4
1,500-1,999	2.8
2,000-3,499	3.6
3,500 or more	7.2

~~(2) For the types of violations listed below in (b)(4) and (b)(5), each violation shall have a penalty amount, as specified of $ 100 in (b)(4) or $ 50 in (b)(5). The penalty amount specified in (b)(4) and (b)(5) shall be waived if the investigation subject's performance rating meets or exceeds eighty-five percent, or if following a Routine Investigation the claims administrator or utilization review organization agrees in writing to:~~

~~(A) Deliver to the Administrative Director, or his or her designee, within no more than thirty (30) calendar days from the date of the agreement or the number of days otherwise specified, written evidence, tendered with a declaration made under penalty of perjury, that explains or~~

~~demonstrates how the violation has been abated in compliance with the applicable statute or regulations and the terms of abatement specified by the Administrative Director; and~~

~~(B) Grant the Administrative Director, or his or her designee, entry, upon request and within the time frame specified in the agreement, to the site at which the violation was found for a Return Target Investigation for the purpose of verifying compliance with the abatement measures reported in subdivision 9792.12(b)(12)(A) above and agree to a review of randomly selected requests for authorization; and~~

~~(C) Reinstatement of the penalty amount previously waived for each such instance, in the event the violative condition is not abated within the time period specified by the Administrative Director, or his or her designee, or in the event that such abatement measures are not consistent with abatement terms specified by the Administrative Director, or his or her designee.~~

(3) In the event the Administrative Director, or his or her designee, returns for a Return Target Investigation, after the initial violation has become final, and the subject fails to meet the performance standard of 85%, the amount of penalty shall be calculated as described below and in no event shall the penalty amount be waived:

(A) The penalty amount for each violation shall be multiplied by two for a second investigation, but in no event shall the total penalties for the violations exceed $ 100,000;

(B) The penalty amount for each violation shall be multiplied by five for a third investigation, but in no event shall the total penalties for the violations exceed $ 200,000;

(C) The penalty amount for each violation shall be multiplied by ten for a fourth investigation, but in no event shall the total penalties for the violations exceed $ 400,000.

~~(4) For each of the violations listed below, the penalty amount shall be $ 100.00 for each instance found by the Administrative Director, or his or her designee:~~

~~(A) For failure to immediately notify all parties in the manner described in section 9792.9(g)(2) of the basis for extending the decision date for a request for medical treatment;~~

~~(B) For failure to document efforts to obtain information from the requesting party prior to issuing a denial of a request for authorization on the basis of lack of reasonable and necessary information;~~

~~(C) For failure to make a decision to approve or modify or deny the request for authorization, within five (5) working days of receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by section 9792.9(g)(3);~~

~~(D) For failure to make and communicate a retrospective decision to approve, modify, or deny the request, within thirty (30) working days of receipt of the information, as required by section 9792.9(g)(4);~~

(E) For failure to include in the written decision that modifies, delays or denies authorization, all of the items required by section 9792.9(j);

(F) For failure to disclose or otherwise to make available, if requested, the Utilization Review criteria or guidelines, to the injured employee whose case is under review, as required by Labor Code section 4610(f)(5) and section 9792.8(a)(3) Title 8 of the California Code of Regulations.

(5) For each of the violations listed below, the penalty amount shall be $ 50.00 for each instance found by the Administrative Director, or his or her designee:

(A) For failure by a non-physician or physician reviewer to timely notify the requesting physician, as required by section 9792.9(b)(2), that additional information is needed in order to make a decision in compliance with the timeframes contained in section 9792.9(b);

(B) For failure to communicate the decision to approve to the requesting physician in the case of prospective or concurrent review, by phone or fax within 24 hours of the decision, as required by Labor Code section 4610(g)(3)(A) and in accordance with section 9792.9(b)(3) of Title 8 of the California Code of Regulations;

(C) For failure to send a written notice of the decision to modify, delay or deny to the requesting party, and to the injured employee and to his or her attorney if any, within twenty four (24) hours of making the decision for concurrent review, or within two business days for prospective review, as required by Labor Code section 4610(g)(3)(A) and section 9792.9(b)(4) of Title 8 of the California Code of Regulations;

(D) For failure to communicate a decision in the case of retrospective review as required by section 9792.9(c) within thirty (30) days of receipt of the medical information that was reasonably necessary to make the determination;

(E) For failure to provide immediately a written notice to the requesting party that a decision on the request for authorization cannot be made within fourteen (14) days for prospective and concurrent reviews, or within thirty (30) days for retrospective in accordance with section 9792.9(g)(2);

(F) For failure to document that one of the following events occurred prior to the claims administrator providing written notice for delay under Labor Code section 4610(g)(5):

(1) the claims administrator had not received all of the information reasonably necessary and requested;

(2) the employer or claims administrator has requested a consultation by an expert reviewer;

(3) the physician reviewer has requested an additional examination or test be performed;

(G) For failure to explain in writing the reason for delay as required by section 9792.9(g)(2) of Title 8 of the California Code of Regulations when the decision to delay was made under one of

~~the circumstances listed in section 9792.9(g)(1).~~

~~(6) After the time to file an answer to the Order to Show Cause Re: Assessment of Administrative Penalties has elapsed and no answer has been filed or after any and all appeals have become final, the Administrative Director, or his or her designee, shall post on the website for the Division of Workers' Compensation the performance rating and summary of violations for each utilization review investigation.~~

(4) The Administrative Director, or his or her designee, shall post on the website for the Division of Workers' Compensation the performance rating and summary of violations for each utilization review investigation upon confirmation of full compliance or after any and all appeals have become final.

(d)~~(c)~~ The penalty amounts specified for violations under subsection 9792.12(a) and (b) above may, in the discretion of the Administrative Director, be reduced after consideration of the factors set out in section 9792.13 of Title 8 of the California Code of Regulations. ~~Failure to abate a violation found under section 9792.12(b)(4) and (b)(5), in the time period or in a manner consistent with that specified by the Administrative Director, or his or her designee, shall result in the assessment of the full original penalty amount proposed by the Administrative Director for that violation~~.

§ 9792.13. Assessment of Administrative Penalties -- Penalty Adjustment Factors

(a) In any investigation that the Administrative Director deems appropriate, the Administrative Director, or his or her designee, may mitigate a penalty amount imposed under section 9792.12 after considering each of these factors:

(1) The medical consequences or gravity of the violation(s);

(2) The good faith of the claims administrator or utilization review organization. Mitigation for good faith shall be determined based on documentation of attempts to comply with the Labor Code and regulations and shall result in a reduction of 20% for each applicable penalty;

(3) The history of previous penalties;

(4) The frequency of violations found during the investigation giving rise to a penalty; and

(5) Penalties may be mitigated outside the above mitigation guidelines in extraordinary circumstances, when strict application of the mitigation guidelines would be clearly inequitable; ~~and~~

~~(6) In the event an objection or appeal is filed pursuant to subsection 9792.15 of these regulations, whether the claims administrator or utilization review organization abated the alleged violation within the time period specified by the Administrative Director or his or her designee.~~

(b) The Administrative Director, or his or her designee, may assess both an administrative penalty under Labor Code section 4610 and a civil penalty under subdivision (e) of Labor Code section 129.5 based on the same violation(s).

(c) The Administrative Director, or his or her designee, shall not collect payment for an administrative penalty under Labor Code section 4610 from both the utilization review organization and the claims administrator for an assessment based on the same violation(s).

(d) Where an injured worker's or a requesting provider's refusal to cooperate in the utilization review process has prevented the claims administrator or utilization review organization from determining whether there is a legal obligation to perform an act, the Administrative Director, or his or her designee, may forego a penalty assessment for any related act or omission. The claims administrator or utilization review organization shall have the burden of proof in establishing both the refusal to cooperate and that such refusal prevented compliance with the relevant applicable statute or regulation.

§ 9792.14. Liability for Penalty Assessments

(a) If more than one claims administrator or utilization review organization has been responsible for a claim file, utilization review file or other file that is being investigated, penalties may be assessed against each such entity for the violation(s) that occurred during the time each such entity had responsibility for the file or for the utilization review process.

(b) The claims administrator or utilization review organization is liable for all penalty assessments made against it, except that if the subject of the investigation is acting as an agent, the agent and the principal are jointly and severally liable for all penalty assessments resulting from a given investigation. This paragraph does not prohibit an agent and its principal from allocating the administrative penalty liability between them. Liability for civil penalties assessed pursuant to Labor Code section 129.5(e) for violations under Labor Code section 4610 or sections 9792.6 through 9792.10 of Title 8 of the California Code of Regulations shall not be allocated.

(c) Successor liability may be imposed on a claims administrator or utilization review organization that has merged with, consolidated, or otherwise continued the business of a corporation, other business entity or other person that was cited by the Administrative Director for violations of Labor Code section 4610 or sections 9792.6 through 9792.12. The surviving entity or person responsible for administering the utilization review process for an employer, shall assume and be liable for all the liabilities, obligations and penalties of the prior corporation or business entity. Successor liability will be imposed if there has been a substantial continuity of business operations and/or the new business uses the same or substantially the same work force.

§ 9792.15. Administrative Penalties Pursuant to Labor Code §4610 -- Answer~~Order to Show Cause~~, Notice of Hearing, Determination and Order, and Review Procedure

(a) Pursuant to Labor Code section 4610(i), the Administrative Director shall issue a final investigation report, notice of utilization review penalty assessment and the performance rating

~~an Order to Show Cause Re: Assessment of Administrative Penalty~~ when the Administrative Director, or his or her designee (the investigating unit of the Division of Workers' Compensation), has reason to believe that an employer, insurer or other entity subject to Labor Code section 4610 has failed to meet any of the requirements of this section or of any regulation adopted by the Administrative Director pursuant to the authority of section 4610.

(b) The final investigation report, notice of utilization review penalty assessment and the performance rating ~~order~~ shall be in writing and ~~shall include all of the following:~~

~~(1) Notice that an administrative penalty may be assessed;~~

~~(2) The final investigation report, which shall consist of the notice of utilization review penalty assessment, the performance rating, and may include one or more requests for documentation or compliance;~~

~~(c) The~~ ~~order~~ shall be served personally or by registered or certified mail.

(d) Within thirty (30) calendar days after the date of service of the final investigation report, ~~Order to Show Cause Re: Assessment of Administrative Penalties~~, the claims administrator or utilization review organization may pay the assessed administrative penalties and comply with request for submission of additional documentation or compliance. or file an answer as the respondent with the Administrative Director, in which the respondent may:

(1) Admit or deny in whole or in part any of the ~~allegations~~ issues set forth in the final investigation report ~~Order to Show Cause~~;

(2) Contest the amount of any or all proposed administrative penalties;

(3) Contest the existence of any or all of the violations;

(4) Set forth any affirmative and other defenses;

(5) Set forth the legal and factual bases for each defense.

(e) Compliance with ~~A~~any allegations, issues and payment of any proposed penalty stated in the final investigation report ~~Order to Show Cause~~ that is not contested ~~shall be paid~~ is due within thirty (30) calendar days after the receipt ~~date of service~~ of the final investigation report ~~Order to Show Cause~~.

(f) Failure to timely file an answer shall constitute a waiver of the respondent's right to an evidentiary hearing. Unless set forth in the answer, all defenses to the final investigation report ~~Order to Show Cause~~ shall be deemed waived. If the answer is not timely filed, within ten (10) days of the date for filing the answer, the respondent may file a written request for leave to file an answer. The respondent may also file a written request for leave to assert additional defenses, which the Administrative Director may grant upon a showing of good cause.

(g) The answer shall be in writing and signed by, or on behalf of, the claims administrator or utilization review organization and shall state the respondent's mailing address. It need not be verified or follow any particular form.

(1) The respondent must file the original and one copy of the answer on, the Administrative Director and concurrently serve one copy of the answer on the investigating unit of the Division of Workers' Compensation (designated by the Administrative Director). The original and all copies of any filings required by this section shall have a proof of service attached.

(h) Within sixty (60) calendar days of the issuance of the final investigation report ~~Order to Show Cause Re: Assessment of Administrative Penalty~~, the Administrative Director shall issue the Notice of the date, time and place of a hearing. The date of the hearing shall be at least ninety calendar days from the date of service of the Notice. The Notice shall be served personally or by registered or certified mail. Continuances will not be allowed without a showing of good cause.

(i) At any time before the hearing, the Administrative Director may file or permit the filing of an amended final report ~~complaint~~ or supplemental notice of utilization review penalty assessment and performance rating ~~Order to Show Cause~~. All parties shall be notified thereof. If the amended final report or notice of utilization review penalty assessment ~~complaint or supplemental Order to Show Cause~~ presents new charges, the Administrative Director shall afford the respondent a reasonable opportunity to prepare its defense, and the respondent shall be entitled to file an amended answer.

(j) At the Administrative Director's discretion, the Administrative Director may proceed with an informal pre-hearing conference with the respondent in an effort to resolve the contested matters. If any or all of the issues ~~violations~~ or proposed penalties in the notice of utilization review penalty assessment ~~Order to Show Cause~~, the amended notice of utilization review penalty assessment ~~Order~~ or the supplemental notice of utilization review penalty assessment ~~Order~~ remain contested, those contested matters shall proceed to an evidentiary hearing.

(k) Whenever the Administrative Director's final investigation report ~~Order to Show Cause~~ has been contested, the Administrative Director may designate a hearing officer to preside over the hearing. The authority of the Administrative Director or the designated hearing officer shall include, but is not limited to: conducting a pre-hearing settlement conference; setting the date for an evidentiary hearing and any continuances; issuing subpoenas for the attendance of any person residing anywhere within the state as a witness or party at any pre-hearing conference and hearing; issuing subpoenas duces tecum for the production of documents and things at the hearing; presiding at the hearings; administering oaths or affirmations and certifying official acts; ruling on objections and motions; issuing pre-hearing orders; and preparing a Recommended Determination and Opinion based on the hearing.

(l) The Administrative Director or the designated hearing officer shall set the time and place for any pre-hearing conference on the contested matters in the final investigation report ~~Order to Show Cause~~, and shall give sixty (60) calendar days written notice to all parties.

(m) The pre-hearing conference may address one or more of the following matters:

(1) Exploration of settlement possibilities;

(2) Preparation of stipulations;

(3) Clarification of issues;

(4) Rulings on the identity of witnesses and limitation of the number of witnesses;

(5) Objections to proffers of evidence;

(6) Order of presentation of evidence and cross-examination;

(7) Rulings regarding issuance of subpoenas and protective orders;

(8) Schedules for the submission of written briefs and; schedules for the commencement and conduct of the hearing;

(9) Any other matters as shall promote the orderly and prompt conduct of the hearing.

(n) The Administrative Director or the designated hearing officer shall issue a pre-hearing order incorporating the matters determined at the pre-hearing conference. The Administrative Director or the designated hearing officer may direct one or more of the parties to prepare the pre-hearing order.

(o) Not less than thirty (30) calendar days prior to the date of the evidentiary hearing, the respondent shall file and serve the original and one copy of a written statement with the Administrative Director or the designated hearing officer specifying the legal and factual bases for its answer and each defense, listing all witnesses the respondent intends to call to testify at the hearing, and appending copies of all documents and other evidence the respondent intends to introduce into evidence at the hearing. A copy of the written statement and its attachments shall also concurrently be served on the investigating unit of the Division of Workers' Compensation. If the written statement and supporting evidence are not timely filed and served, the Administrative Director or the designated hearing officer shall dismiss the answer and issue a written Determination based on the evidence provided by the investigating unit of the Division of Workers' Compensation. Within ten (10) calendar days of the date for filing the written statement and supporting evidence, the respondent may file a written request for leave to file a written statement and supporting evidence. The Administrative Director or the designated hearing officer may grant the request, upon a showing of good cause. If leave is granted, the written statement and supporting evidence must be filed and served no later than ten (10) calendar days prior to the date of the hearing.

(p) Oral testimony shall be taken only on oath or affirmation.

(q)(1) Each party shall have these rights: to call and examine witnesses, to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter

was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence.

(2) In the absence of a contrary order by the Administrative Director or the designated hearing officer, the investigating unit of the Division of Workers' Compensation shall present evidence first.

(3) The hearing need not be conducted according to the technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make the admission of the evidence improper over objection in civil actions.

(4) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but upon timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case to the Administrative Director or to the designated hearing officer.

(r) The written affidavit or declaration of any witness may be offered and shall be received into evidence provided that (i) the witness was listed in the written statement pursuant to section 9792.15(n); (ii) the statement is made by affidavit or by declaration under penalty of perjury; (iii) copies of the statement have been delivered to all opposing parties at least twenty (20) days prior to the hearing; and (iv) no opposing party has, at least ten (10) days before the hearing, delivered to the proponent of the evidence a written demand that the witness be produced in person to testify at the hearing. The Administrative Director or the designated hearing officer shall disregard any portion of the statement received pursuant to this regulation that would be inadmissible if the witness were testifying in person, but the inclusion of inadmissible matter does not render the entire statement inadmissible. Upon timely demand for production of a witness in lieu of admission of an affidavit or declaration, the proponent of that witness shall ensure the witness appears at the scheduled hearing and the proffered declaration or affidavit from that witness shall not be admitted. If the Administrative Director or the designated hearing officer determines that good cause exists that prevents the witness from appearing at the hearing, the declaration may be introduced in evidence, but it shall be given only the same effect as other hearsay evidence.

(s) The Administrative Director or the designated hearing officer shall issue a written Determination and Order Assessing Penalty, if any, including a statement of the basis for the Determination and each penalty assessed, within sixty (60) days of the date the case was submitted for decision, which shall be served on all parties. This requirement is directory and not jurisdictional.

(t) The Administrative Director shall have sixty (60) calendar days to adopt or modify the Determination and Order Assessing Penalty issued by the Administrative Director or the designated hearing officer. In the event the recommended Determination and Order of the designated hearing officer is modified, the Administrative Director shall include a statement of the basis for the Determination and Order Assessing Penalty signed and served by the

Administrative Director, or his or her designee. If the Administrative Director does not act within sixty (60) calendar days, then the recommended Determination and Order shall become the Determination and Order on the sixty-first calendar day.

(u) The Determination and Order Assessing Penalty shall be served on all parties personally or by registered or certified mail by the Administrative Director.

(v) The Determination and Order Assessing Penalty, if any, shall become final on the day it is served, unless the aggrieved party files a timely Petition Appealing the Determination of the Administrative Director. All findings and assessments in the Determination and Order Assessing Penalty not contested in the Petition Appealing the Determination of the Administrative Director shall become final as though no petition were filed.

(w) At any time prior to the date the Determination and Order Assessing Penalty becomes final, the Administrative Director or designated hearing officer may correct the Determination and Order Assessing Penalty for clerical, mathematical or procedural error(s).

(x) Penalties assessed in a Determination and Order Assessing Penalty shall be paid within thirty (30) calendar days of the date the Determination and Order became final. A timely filed Petition Appealing the Determination of the Administrative Director shall toll the period for paying the penalty assessed for the item appealed.

(y) All appeals from any part or the entire Determination and Order Assessing Penalty shall be made in the form of a Petition Appealing the Determination of the Administrative Director, in conformance with the requirements of chapter 7, part 4 of Division 4 of the Labor Code. Any such Petition Appealing the Determination of the Administrative Director shall be filed at the Appeals Board in San Francisco (and not with any district office of the Workers' Compensation Appeals Board), in the same manner specified for petitions for reconsideration.